The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.osc.ct.gov/benefits/docs/MedicalPlanDoceff1012016updt9132016.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-922-2232 (Anthem) or 1-800-385-9055 (Oxford) to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | In-network: $350/Individual; $4,000/Family<br>Waived for HEP Members and pre-October 2, 2011, Retirees. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Medical: In-network: $2,000/individual; $4,000/family<br>Prescription drugs: $4,600/individual; $9,200/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Out-of-network deductibles and cost sharing, premiums, balance-billing, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a network provider? | Yes. See:<br>www.anthem.com/statect or call 1-800-922-2232 or<br>http://stateofct.welcometouhc.com/home or call 800-385-9055 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

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| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $15 copay/visit<br>Pre-1999 retirees: $5 copay/visit | Not Covered | Must select a primary care physician to coordinate care if enrolled in POE-G option |
| | Specialist visit | $15 copay/visit<br>Pre-1999 retirees: $5 copay/visit | Not covered | Members enrolled in the POE-G option must select a primary care physician and referrals are required for all specialist services. |
| | Preventive care/screening/ immunization | No charge.<br>Deductible will not apply. | Not covered | One physical exam/year for members over 19.<br>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services. |

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| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at http://www.osc.ct.gov/benefits/pharmacy.htm | Generic drugs | $5 copay/retail; $5 copay/mail order.<br>Pre-July 1, 2009 Retirees: $3 copay/retail; $0 copay/mail order. | 20% coinsurance for refills at non-participating pharmacy | Deductible does not apply to prescription drugs. See details of your coverage for slightly adjusted copays for persons retired between July 1, 2009 and October 1, 2011, and after October 1, 2011. Check details at: http://www.osc.ct.gov/benefits/pharmacy.htm<br>Maintenance drugs must be filled by mail order after first retail fill.<br>Penalty may apply if brand name drug is requested when a generic is available.<br>Some drugs require prior authorization. No charge for FDA-approved contraceptives (or brand name contraceptives if generic is medically inappropriate).<br>Prescription drugs purchased at retail pharmacy limited to a maximum 30-day supply; prescription drugs purchased through mail order or maintenance network pharmacy limited to a maximum 90-day supply. |
| | Preferred brand drugs | $20 copay/retail; $10 mail order.<br>Pre-July 1, 2009 Retiree: $6 copay retail; $0 copay/mail order | | |
| | Non-preferred brand drugs | $35 copay/retail; $25 copay/mail order.<br>Pre-July 1, 2009 Retiree: $6 copay/retail; $0 copay/mail order | | |
| | Specialty drugs | Same as non-preferred brand drugs | Same as non-preferred brand drugs | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services. |
| | Physician/surgeon fees | No charge | Not covered | |
| If you need immediate medical attention | Emergency room care | $35 copay/visit.<br>Pre-October 2, 2011 Retiree: No Charge. | 35 copay/visit.<br>Pre-October 2, 2011 Retiree: No charge | Copayment waived if admitted. |
| | Emergency medical transportation | No charge | Not Covered | None. |
| | Urgent care | $15 copay/visit.<br>Pre-1999 Retiree: $5 copay/visit | Not covered | Out-of-network services not covered except urgent care services when traveling outside the United States |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.<br>No coverage in excess of cost of a semi-private room unless medically necessary. |
| | Physician/surgeon fees | No charge | Not covered | |

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| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $15 copay/visit. Pre-1999 Retiree: $5 copay/visit | Not covered | None. |
| | Inpatient services | No charge | Not covered | Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services. |
| If you are pregnant | Office visits | $15 copay/visit. Pre-1999 Retiree: $5 copay/visit. | Not covered | No cost share for preventive services. Maternity care may include tests and services described under another section (i.e., ultrasound). |
| | Childbirth/delivery professional services | No charge | Not covered | Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services. |
| | Childbirth/delivery facility services | No charge | Not covered | |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | Limit: 200-visits/calendar year. |
| | Rehabilitation services | No charge | Not covered | Prior authorization required (except pre-1999 retirees) to avoid penalty of lesser of $500 or 20% of cost of services.<br>Speech therapy limited to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx. |
| | Habilitation services | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Skilled nursing care | No charge | Not covered | Requires prior authorization to avoid penalty of lesser of $500 or 20% of cost of services. |
| | Durable medical equipment | No charge | Not covered | Requires prior authorization to avoid penalty of lesser of $500 or 20% of cost of services. |
| | Hospice services | No charge | Not covered | Requires prior authorization to avoid penalty of lesser of $500 or 20% of cost of services. |
| If your child needs dental or eye care | Children's eye exam | $15 copay/visit | Not covered | 1 exam visit/calendar year.<br>Copay waived for HEP members alternate years |
| | Children's glasses | Not covered | Not covered | You must pay 100% of this service, even in-network. |
| | Children's dental check-up | Not covered | Not covered | You must pay 100% of this service, even in-network. You can enroll in a dental plan separately. |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Children's dental check-up<br>• Children's glasses<br>• Cosmetic surgery | • Dental care (adult)<br>• Habilitation services<br>• Long-term care | • Routine foot care<br>• Weight loss programs (except as required by the health reform law) |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (limited to 20 visits/year by Oxford; covered only if medically necessary for osteoarthritis or nausea and vomiting associated with surgery, chemotherapy or pregnancy by Anthem). | • Bariatric surgery (prior authorization required)<br>• Chiropractic care<br>• Hearing aid (one set per 24 month period; prior authorization may be required for bone-anchored devices) | • Infertility treatment (prior authorization required)<br>• Non-emergency care outside the U.S. (urgent care only)<br>• Private duty nursing (prior authorization required)<br>• Routine eye care (Adult) (1 exam/year) |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

| | | |
|---|---|---|
| Anthem Blue Cross and Blue Shield<br>108 Leigus Road<br>Wallingford, CT 06492<br>800-922-2232 | UnitedHealthcare/Oxford<br>P.O. Box 30432<br>Salt Lake City, UT 84130-0432<br>Member Service Associates: 800-385-9055 | CVS/Caremark<br>Prescription Claim Appeals MC109<br>P.O. Box 52084<br>Phoenix, AZ 85072-2084<br>Fax: 866-4431172 |

Additionally, a consumer assistance program can help you file your appeal. Contact:

Connecticut Office of the Healthcare Advocate
P.O. Box 1543
Hartfod, CT 06144
833-466-4446
www.ct.gov/oha
healthcare.advocate@cta.gov

## Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-385-9055.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-385-9055.

如果需要中文的帮助，☒☒打☒个号☒ 1-800-385-9055.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-385-9055.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $350 |
| Specialist *[cost sharing]* | $5 |
| Hospital (facility) *[cost sharing]* | $0 |
| Other *[cost sharing]* | $0 |

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| Total Example Cost | $12,800 |
|---|---|

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $20 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $430 |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $350 |
| Specialist *[cost sharing]* | $5 |
| Hospital (facility) *[cost sharing]* | $0 |
| Other *[cost sharing]* | $0 |

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| Total Example Cost | $7,400 |
|---|---|

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $560 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Joe would pay is | $970 |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $350 |
| Specialist *[cost sharing]* | $5 |
| Hospital (facility) *[cost sharing]* | $0 |
| Other *[cost sharing]* | $0 |

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| Total Example Cost | $1,900 |
|---|---|

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $450 |

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please visit http://osc.ct.gov/benefits.htm.

The plan would be responsible for the other costs of these EXAMPLE covered services.